STATEMENT FOR THE RECORD

of

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on

THE COMMISSIONED CORPS
OF THE
U.S. PUBLIC HEALTH SERVICE

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HOUSE COMMITTEE
ON
GOVERNMENT REFORM

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As a former Surgeon General of the U.S. Public Health Service I retain a deep and abiding respect for the dedication of the officers of the PHS Commissioned Corps. Accordingly, I appreciate the invitation of the House Committee on Government Reform to testify on the role and organization of the Corps as they continue their critically important work for the Nation.

There is little information available to the public concerning the details of the plan of the Department of Health and Human Services to reorganize or "transform" the PHS Commissioned Corps. My remarks will be based on what I have learned in discussions with others more familiar with the specifics of the HHS plans, and also on my experience over eight years as the Surgeon General.

Let me begin by stating my support for Secretary Thompson's vision and initiative in recognizing the need for improvements in the Corps. I endorse the need for change. The concerns I will express in this testimony have more to do with organization and process, matters I am sure the Secretary has left to subordinates; I am not here to criticize the overall goal of a strengthened Commissioned Corps and improved public health.

I am the only living person who was Surgeon General and leader of the PHS Commissioned Corps under two organizational concepts. One system worked well and the other was inefficient, tied the hands of the willing, competent experts where initiatives were stifled by bureaucrats with no real solutions in mind. The system undermined the morale of the Corps. I believe, therefore, that

I am uniquely qualified to comment on what is in the best interests of public health as influenced by the Commissioned Corps.

For the Corps to reach its full potential in protecting and promoting the public health the following changes are important:

- The Office of the Surgeon General, that is the Surgeon General and his staff (OSG), must have complete and direct control over all aspects of the day-to-day administration, management, and operation of the Corps. This is the system which worked after the revitalization of the Corps which I undertook with the guidance and full support of the Secretary of Health and Human Services, Otis Bowen. Its models are and should be the other uniformed services as well as the organization of any successful business enterprise.
- The Corps needs to develop the ability to better define requirements, including personnel requirements. This is no small task. It was an important part of my efforts to revitalize the Corps, even though – in the three years available to me – we were not able to fully implement the changes we sought. Once personnel requirements are documented, the Corps will then be able to move forward with improvements to its overall recruiting and assignment strategy.
- The growing need for the Commissioned Corps to respond to emergency situations – whether natural disasters or the result of man made terrorist actions – seems to mandate a demand for some sort of robust ready reserve component, similar to the reserve components of the other uniformed services. This reserve force could function as either a backfill for officers

deployed from clinical positions such as those in the Indian Health Service, or perhaps even as the response force itself. The key to emergency response, of course, is the training, organization, and exercising of the response force well in advance of any emergency. This will require considerable thought before instituting change, evaluation of trial and error and then re-evaluation, and of course, funding.

- I fully support any initiative to expand the size and enhance the capability of the Corps, as well as any activity designed to improve its professionalism. In order to achieve an increase in size and capability the Corps must be able to relate such growth to a requirement. I believe the requirement exists, but it will take some effort to establish the data to support an expanded Corps. Mission must be matched to requirements which in turn must be assessed in terms of available resources. Efforts to improve professionalism should include a continuum of educational opportunities from pre-commissioning through indoctrination in executive level management, administration, leadership and officership for those selected to flag rank.
- The Corps has functioned best when officers were rotated every three years through say, Indian Health Service, Bureau of Prisons, PHS agencies, and then a period of "refreshment" in one of the PHS hospitals. The hospitals, except for those in the Indian Health Service, were closed in 1981 which severely impacted the opportunities to educate and re-educate our officers. Attention must be given to some alternate plan which would include bioterrorism updates.

My concerns about the contemplated reorganization of the Commissioned Corps are that the plans do not support the important changes listed above. The system that did not work well for me from my confirmation in November of 1981 until revitalization in 1987 failed because personnel management of Corps officers was separated from any control or direction by the Office of the Surgeon General. From then until I left office at the end of my second four-year term in 1989, the new system worked well. In 1995, much to my dismay, personnel management functions were moved again, this time under the HHS Assistant Secretary for Administration and Management. As a result, the Corps has experienced difficulties in recruiting and placement of officers and has continued, until very recently, to slowly grow smaller – hardly the system that would foster the desired increase in the size of the Corps.

The new plan appears to even further fragment the day-to-day administration and management of the Corps. I do not understand the need for a new office, responsible for day-to-day management and operation which reports to the Assistant Secretary for Health on a co-equal basis with the Surgeon General. What then, is the role of the Surgeon General for leadership of the Corps, which is one of the principal functions for which he is nominated and confirmed? Leaving the important functions of compensation and medical affairs under the authority of still another assistant secretary will add confusion and inefficiency where least needed. I used to call this the "onion syndrome", covering a mistake in organizational change with another layer to further confuse the issue – but like an onion, the outer layer neatly hides the layers below it.

The plans, as I understand them, appear to devalue the role of Corps officers in fundamental public heath roles – those who are engaged in research, laboratory work, and regulatory activities. Providing clinical health care to underserved populations is a critically important aspect of public health. But it is not the only aspect of public health. Equally important is the work conducted by Corps officers at institutions like CDC, NIH and FDA. The growing importance of emergency response and deployability of Corps officers has the potential to cause conflict with the more traditional roles of Corps officers. The world takes on the standards of the FDA, and the NIH is the premiere source of medical research on this planet and the CDC is pre-eminent in international health. At any one time about 200 CDC personnel are abroad doing what no one else does better.

We forget, at our peril, the great synergy which the Corps brings to public health. The common identity and unity of purpose of these dedicated health professionals in their diverse assignments has been a key factor in the many successes wrought by our Public Health Service.

Failure to get the process right by which change is imposed on the Corps is bound to doom the outcome. My concern is that, in the Department's rush to fix one problem; they will create two more if the process is not engineered correctly. Mission drives requirements, which are tempered by resources. Plans are then developed to match resources against prioritized requirements, all consistent

with the goal of achieving the mission. It appears to me, we are beginning with the plans first.

The PHS Commissioned Corps has been evolving and changing with emerging threats to public health ever since it was founded. Twenty years ago, during my tenure, we were engaged in a revitalization of the Corps. Today there are new threats emerging. The confusion surrounding the anthrax episodes in the fall of 2001 pointed out some problems with the ability of our public health infrastructure to respond to the threat of bioterrorism. We have continuing problems with finding sufficient health care providers for some underserved communities. The increasingly rapid spread of new diseases, such as SARS, demands improvements to our research capabilities. All of these things point to the need to continually improve the forces at hand to protect our public health.

We invested considerable resources in a revitalization of the Commissioned Corps during my tenure as Surgeon General. We conducted all manner of studies supporting the need for a stronger, larger, more capable Corps. Many of those studies would still, no doubt be valid today. But any new initiative to transform the Corps must first begin with a revalidation of the Corps' mission and role in public health. I would argue for an increased role for the Corps and the Surgeon General in leading the public health infrastructure at all levels. The Corps' role in emergency preparedness and response – especially organizational issues – should be carefully evaluated. The relationship of the Commissioned Corps and

OSG to the new Department of Homeland Security role in public health emergency response is also worthy of examination.

One of the greatest challenges in increasing the mobility of the Commissioned Corps in emergency response is the fact that these highly trained and experienced health professionals all have "day jobs." And their "day jobs" are critically important whether they are clinicians on a remote Indian reservation or federal prison or assigned as an epidemiologist or researcher at CDC, perhaps on domestic or foreign detail. You cannot routinely deploy the only pharmacist on a reservation or in a prison without a plan for substitution. Similarly, the life long researcher at CDC may not be the ideal choice to respond to an emergency situation where trauma skills will be the primary need. New responsibilities for the Corps must be carefully balanced against the still important role of the Corps in traditional areas of public health. This can only be successfully accomplished by using a strategic planning process which is organized, inclusive, and data based. My impression of the current process is that it is none of these things.

Future needs of the Corps will be determined and documented with a requirements-based system of billet identification as previously discussed. A requirements based system will drive end strength which, in turn, will drive recruiting and other force shaping policies and programs such as promotions, bonuses, etc.

Much has been written in the past two years about the urgent need for improvement in the nation's public health infrastructure. The Surgeon General is clearly recognized as the top public health professional in the country. The Office of the Surgeon General ought to be empowered to take charge of the infrastructure and develop the changes necessary to make it better. The Commissioned Corps is one logical, in place tool at the Surgeon General's disposal to make this happen. It will require additional resources and it must be based, again, on a validation of the mission of the Corps.

To do less unnecessarily risks the public health of this great Nation.

Lord, Michael W., COA Statement for the Record, Testimony before the Senate Health, Education, Labor and Pensions Committee, Subcommittee on Public Health and Safety, March 25, 1999.

[2] "The Future of the Public's Health in the 21st Century, Institute of Medicine, Washington, DC, November 11, 2002.

[3] Rosner, David and Markowitz, Gerald, "September 11 and the Shifting Priorities of Public and Population Health in New York," Milbank Memorial Fund, May 2003.

[4] Kott, Andrea, "Warning: The State of Public Health in America Not So Healthy", *Advances*, The Robert Wood Johnson Foundation, Princeton, NJ, Issue 1, 2002.

[5] Kluger, Jeffrey, "A Public Mess", *TIME*, January 21, 2002

[6] USPHS Commissioned Corps Transformation Initiatives – Draft document (Power Point Presentation)– 8/12/03

[7] Remarks to CDC "All hands" meeting for Corps officers, 8 October 2003.

[8] Former ASHs Robert Windom and Julius Richmond and former Surgeon General C. Everett Koop. In a letter dated September 10, 2003 Dr. Windom wrote "The ASH and SG are impotent, placed aside by persons who have no interest in PHS. This incompetence must not be allowed to continue, and the PHS must be restored to its previous vitality."

[9] FDA Commissioner letter to DHHS Secretary dated August 15, 2003.

[10] Blakency, Barbara, President, American Nurses Association, in a letter to DHHS Secretary Thompson dated 1 August 2003.

[11] Kates, Brian, "U.S. Bioterror Plans Ripped", *New York Daily News*, Sunday, October 12, 2003.